FILED APR 12 1940

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

10192
Do not use this space.

85

1. PLACE OF DEATH
(a) County Buchanan Registration District No.
(b) Township or City St Joseph Primary Registration District No. 1001 Registered No. 268
(c) (d) Street No. State Hospital #2 St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred 3 yrs. 6 mos. 9 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Orsie Ernest Sego (ORSIE ERNEST SEGO)
(a) Residence, No. State Hospital #2 St. Ruskville, Mo.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): divorced
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: no information
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Oct. 24, 1888
7. AGE: YEARS 51 | MONTHS 4 | DAYS 10 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: farmer
9. Industry or business in which work was done, as saw mill, bank, etc.: chronic invalid
10. Date deceased last worked at this occupation (month and year): [illegible]
11. Total time (years) spent in this occupation:

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): [illegible] Mo.

FATHER
13. NAME: James Milton Sego
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Daviess Co. Mo.

MOTHER
15. MAIDEN NAME: Ella Willis
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Daviess Co. Mo.

17. INFORMANT (ADDRESS): Sidney V. Sego 1037 Parallel Atchison Kan.
18. BURIAL, CREMATION, OR REMOVAL: Sugar creek cem
PLACE Ruskville Mo DATE 3-7 1940
19. FUNERAL DIRECTOR (NAME) (ADDRESS): Wm D Stanton Atchison, Kans.
20. FILED MAR 6, 1940 A. J. Nestlebush Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): Mar. 5 1940
22. I HEREBY CERTIFY, That I attended deceased from June 24, 1936, to Mar. 5, 1940
I last saw h[illegible] alive on Mar. 5, 1940 Death is said to have occurred on the date stated above, at 4:40 P m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Epileptic deterioration	?

Other contributory causes of importance:
Multiple pulmonary abscesses | Jan. 1940

Name of operation none Date of
What test confirmed diagnosis? Clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury, 19
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) J. T. O'Dell M. D.
(Address) State Hosp #2

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD

I X16605

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Wm Stanton

Licensed Embalmer No. 3778

P. O. Address Atchison Kans

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

No. 28
2-21-40
I X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 101927

Registration District No. 82- Primary Registration District No. 1001 Registrar's No. 268

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St Joseph
(If outside city or town limits write "RURAL" and name of township)

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits write "RURAL")

(d) Street No. (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Orieltment Lenzo

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Div

6. (b) Name of husband or wife

6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 31 Months 4 Days 10 If less than one day: hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 5-29-40 (Date received local registrar) (b) W. J. Nestlehut (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 5-

year 1940 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19 ;

that I last saw h alive on 19 ;

and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Epileptic Deterioration	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death): Multiple Pulmonary abscess	

Major findings:
Of operations
Of autopsy Broncho pneumonia

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)

While at work? (e) Means of injury

23. Signature T. T. Odell (M. D. or other)

Address St Joseph Date signed 5-29-40

State Hosp #2

SUPPLEMENTARY

S-10192 1940